Healing Hands
Home Health Care

# SUPERVISORY VISIT RECORD

Patient's Name: _____ Record #_____
Aide(s) being supervised_____ Date of supervision visit_____

**Home Health Aide Performance** Circle one

| | | | |
|---|---|---|---|
| 1. | The aide(s) follows and implements the care plan | No | Yes |
| 2. | The aide(s) maintains and implements Universal Precaution per agency policy | No | Yes |
| 3. | The aide(s)is prompt, stays required length of time and is reliable | No | Yes |
| 4. | The aide(s)appears competent in the delivery of service | No | Yes |
| 5. | The aide(s)performs tasks as required by the client without job description | No | Yes |
| 6. | The aide(s)relates well with the patient/family | No | Yes |
| 7. | The aide(s)adheres to the dress code | No | Yes |
| 8. | The aide(s)reports complications and problems to case manager/supervisor | No | Yes |
| 9. | The aide(s) is caring and sympathetic to the client's needs | No | Yes |
| 10. | _____ | | |

Patient's comments:

_____

_____

**Home Health Aide Plan Supervision** Circle one

| | | | |
|---|---|---|---|
| 1. | Is the agency admitting folder readily available? | Yes | No |
| 2. | Does the client have a continued need for aide services? | Yes | No |
| 3. | Has the home health aide care plan been updated as required? | Yes | No |
| 4. | _____ | Yes | No |

New needs identified/change in care plan

_____

_____

Instruction/training given to aide(s)

_____

_____

_____

Supervisor's Signature & Title

_____

Signature of Aide (optional)

_____

Patient's Signature (optional)

_____